

Imani Counseling Services

Screening Information

Please Print Clearly THIS SHEET MUST BE FILLED IN COMPLETELY Readmit: Yes No

Date _____ Client's Social Security # _____ Case # _____
Client's First Name _____ Last Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____
Birthdate ____/____/____ Age ____ Gender F M Race _____
Name of Spouse/Guardian _____ Phone _____
Address _____ City _____ State _____ Zip _____
Person Responsible for Payment _____ Soc. Sec. # _____
Signature of Person Responsible for Payment X _____ (Must be signed for services to begin)

EMERGENCY INFORMATION

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Name (2) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____
Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____
Other Physicians _____ Phone _____
Current Medications _____
Allergies _____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____
Spouse: Place _____ Phone _____ Hrs _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____
Phone _____ Phone _____
Contract/ID# _____ Contract/ID# _____
Group/Acct# _____ Group/Acct# _____
Subscriber _____ Subscriber _____
Subscriber Date of Birth _____ Subscriber Date of Birth _____
Client's relationship to Subscriber _____ Client's relationship to Subscriber _____
 Self Spouse Child Other _____ Self Spouse Child Other _____
PROVISIONS: Client pays \$ _____ Deductible amount _____ Amount satisfied: \$ _____
Insurance pays _____ % for visits _____ - _____ and _____ % for visits _____ - _____
Type(s) of providers covered: _____ Supervision: _____
Prior authorization needed: _____
Effective date: _____ Policy anniversary: _____
Coverage for testing: _____ Annual limit: _____

REFERRAL SOURCE

How did you hear of our clinic (or from whom)? _____
Address _____ City _____ State _____ Zip _____
Phone _____ Relationship to referral source _____